Ethics in Psychiatry

ETHICAL ASPECTS OF EVALUATING A PATIENT'S MENTAL CAPACITY

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ABSTRACT

When a patient's mental capacity to make decisions is open to question, the physician often calls in a psychiatrist to help make the determination. The psychiatrist's conclusions may be taken to a court to determine the patient's legal competency. In this article, the author presents several clinical criteria psychiatrists may use when determining patients' mental capacities. The author discusses two critical ethical questions psychiatrists should consider when they use this criteria: (1) whether they should use a fixed or sliding standard and (2) if they adopt a sliding standard, what clinical factors should be given the greatest weight. The author also discusses whether psychiatrists should take initiative to obtain a second opinion from another psychiatrist or mental health professional. Finally, the author discusses research regarding patients who are likely to have more impaired capacity for performing executive functions, patients requesting surgical procedures that are ethically without precedent, and patients possibly having inner awareness under conditions that previously were not considered possible.

KEY WORDS

determination of mental capacity, ethical decision making, clinical decision making, legal competency

INTRODUCTION

When a patient's mental capacity to make decisions is open to question, the physician often calls in a psychiatrist to help make the determination. The psychiatrist's conclusions may be taken to a court to determine the patient's legal competency. Physicians and psychiatrists sometimes assume that the initial psychiatric determination regarding a patient's mental capacity should be regarded clinically as conclusive. This makes sense. The psychiatrist's expertise is, after all, in this area. Ethically, however, this assumption may be unwarranted because the psychiatrist's judgment that a patient has or lacks mental capacity is not wholly clinical. In fact, it cannot be.[1]

The determination of capacity involves two components: a clinical component and an ethical component. When a psychiatrist determines a patient's mental capacity, the psychiatrist must determine not only what the patient *can* do, but also what the patient *should be able* to do when confronted with a situation that requires a decision on the part of the patient. Once this "should" question becomes an issue, it

requires an ethical or normative judgment. This is true in every context in which a "should" question is involved. Someone must determine in these cases involving mental capacity what *should* be as well as what *is*.

The implications of determining a patient's mental capacity for the psychiatrist are far reaching. No matter how clinically gifted a psychiatrist is, his or her moral view may not warrant moral weight when this moral weight would or could be decisive. The reasons for this are self-evident: suppose, as is often the case, that one psychiatrist's moral view differs wholly from another's. When this is the case, a patient's outcome may be determined by this difference, particularly when the decision regarding capacity is more marginal. The actual outcomes resulting from this determination may be profoundly significant. The moral view of the psychiatrist who does the evaluation may determine whether a patient can or cannot choose to refuse life-preserving treatment. The determination of capacity may differ for clinical or moral reasons between two psychiatrists, even if they use the same standard for determining a patient's capacity. For example, in a recent study, forensic psychiatrists and psychologists were asked to determine a person's criminal competency to stand trial using hypothetical cases. They split almost 50/50 despite of the fact that they all used the same legal standard.[2,3]

The outcome of a patient's capacity determination should not be determined ultimately by the moral view of the psychiatrist doing the evaluation. Ethically, an outcome based on a psychiatrist's moral view would not be justifiable because the outcome would be arbitrary. In other words, the outcome would be determined by a view the consulting psychiatrist happened to have. Furthermore, the arbitrary basis of this outcome would violate a second, comparably important ethical principle: equity. For example, suppose two patients were identical in every respect except that they had two different psychiatrists with differing moral beliefs. If both psychiatrists based their determination of their patient's mental capacity to any degree on their own moral beliefs, the determinations for these two patients could be different, and this would violate equity. Therefore, when a psychiatrist is asked to determine a patient's mental capacity, he or she should always try not to impose his or her own moral values on the decision.[4]

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CRITERIA A PSYCHIATRIST MAY USE WHEN DETERMING A PATIENT'S MENTAL CAPACITY

Psychiatrists may use several criteria to assess a patient's mental capacity. Four criteria psychiatrists commonly use are a patient's ability to 1) understand alternatives, 2) appreciate how these alternatives apply to him or herself, 3) reason regarding these alternatives, and 4) express a choice.[5,6] Some psychiatrists feel that these four criteria do not go far enough. Some have proposed that patient choices should be basically consistent with what those patients have valued in the past.[7] Others have gone still further and asserted that patient choices should have some reasonable basis that can be objectively appreciated by others.[8]

The criteria psychiatrists use may be strongly influenced or determined by the applicable law.[9] Yet psychiatrists clinically may use criteria for determining capacity that are different from what the law requires if taken only in its most literal sense, because the clinical concept of competence is wider.[10–12] Gutheil and Appelbaum[13] make this clear in their text on psychiatry and the law. They state, "Although competence is a legal concept and, strictly speaking, can only be determined by a judge, the realities of psychiatric practice require that clinicians often make their own assessments of a patient's likely competence….[Thus,] the mental health professional is confronted with the issue of what standards to apply."[13] Furthermore, even when psychiatrists use certain criteria, they must determine how these criteria should be applied.[10] Judges must do this as well.

Gutheil and Appelbaum[13] go on to say, "Statutes and court decisions have done little to move beyond the vaguest descriptions of what constitutes general competence…It seems apparent, from a review of the law, that the tendency has been to give the judiciary maximal flexibility in determining that an individual is incompetent."[13] Generally, judges place great weight on what psychiatrists tell them—with good reason. The judgment of capacity lies within a psychiatrist's expertise, not the judge's.

Psychiatrists cannot make these decisions based solely on test instruments using "objective" measures; they must ultimately make these determinations themselves. The most frequently

used "objective" test of capacity is the MacCAT-T.[6] This test involves a semistructured interview that assists clinicians in providing patients with information about their specific conditions and treatment options and also prompts clinicians to ask questions that enable the clinicians to assess these patients' understanding and reasoning in regard to the decisions they face. This test is presently regarded as the "gold standard."[10] Other tests of capacity have been devised for special patient groups.[14] Some, like the MacCAT-T, correspond highly with what psychiatrists generally conclude.[10,14] Even though these tests may be valuable to support what a psychiatrist decides, determinations may differ in regard to individual patients.[15] Thus, these tests are now regarded as too limited to be used independently.[10,16,17]

Psychiatrists may try to enhance the validity of their conclusions by using other forms of criteria, such as how a patient lives his or her life. An example here would be a patient's ability to perform life-related tasks in the home.[18] A psychiatrist may also try to enhance a patient's capacity prior to making a mental capacity determination.[9–23] These approaches may include, for example, providing patients with information by additional means, such as videos, and teaching loved ones how to be more supportive of patients so that these patients can become less anxious.[23]

The fixed versus the sliding standard. How should psychiatrists decide which criteria they should use? What ethical factors should they most strongly consider when deciding a patient's capacity? I suggest two primary factors psychiatrists should consider, which are 1) whether there is a significant difference in a patient's likely outcome that would result from whatever pending choices are available to the patient and 2) whether a patient's cognition is likely to be impaired due to his or her emotions. If either of these conditions is present, the psychiatrist should then ask him- or herself the extent to which he wishes to take these conditions into account.[24–26] When the difference in potential outcomes is small and a patient is not likely to be affected by strong emotions, the argument is stronger for the psychiatrist to use a more "fixed" and less flexible standard. Such a standard may only require that a patient be able to understand the alternatives he or she faces enough to "literally" report them. For example, a patient must, at the very least, be able to say, "I know that with this treatment I will live, and that without it, I will die."

The use of a more fixed standard has two main merits: First, it may increase the degree to which a psychiatrist can respect a patient's autonomy. It will be less likely that a psychiatrist will be unjustifiably paternalistic. It may even enhance the patient's mental capacity and allow the patient to be more genuinely autonomous in the long run. Second, these decisions will likely be more consistent not only from case to case, but among different psychiatrists, because each psychiatrist will use the same fixed standard. This consistency may also further the value of equity, as I've discussed previously.

The psychiatrist's use of this standard may, however, violate equity in another way. A more fixed standard may preclude the psychiatrist from adopting a standard geared toward each patient's individual circumstances. Thus, a more fixed standard may prevent the psychiatrist from treating each patient differently, but equally, in that the psychiatrist is adopting a standard he or she feels will best fit *all* patients' needs.

A sliding standard, at the other extreme, furthers this second value of equity. It also allows the psychiatrist to be maximally flexible, though it may be paternalistic. A sliding standard allows the psychiatrist to take into account not only different patients' different outcomes, but also the underlying emotional factors. Emotions can affect a patient's cognition so profoundly that the patient's decision-making capacity becomes distorted.

The fixed standard, once again, is generally less strict and demanding. Principally, it requires that a patient be able to describe his or her alternatives. A psychiatrist using this standard is usually more likely to find that a patient has capacity, even when his or her outcomes will greatly differ and/or the patient has underlying feelings that are profoundly disturbed.

A case example. A 21-year-old man (composite case, not a real patient) was speeding in a car with several friends as his passengers. Due to his speeding, he lost control of his vehicle and crashed, killing everyone in the car but himself. He was paralyzed from the neck down as a result of this crash and was immediately placed on a respirator. Suppose he knew that his friends all died, that it was his speeding that caused their deaths, and that stopping his respirator would result in his own death. And suppose that he requested that his respirator be shut off.

Should the psychiatrist have concluded that this patient had the capacity to end his life? Or should the psychiatrist have concluded that because of the great difference in probable outcomes and/or because of the strong emotions the patient likely was experiencing that he

lacked the capacity, at that moment at least, to make the decision to end his life?

The likely outcomes for this patient radically differed of course. He could have died immediately or lived on for perhaps 80 more years. This patient could not help but be most profoundly affected emotionally. He knew his friends were dead and it was his speeding that killed them. He knew also that if he chose to live, he would most likely be paralyzed for the rest of his life. A fixed standard requiring only literal understanding might have made it easier for the psychiatrist to conclude that this patient had the prerequisite mental capacity to decide to stop the respirator and end his life-preserving care. A sliding standard might have made it easier for the psychiatrist to conclude that the patient did not have the mental capacity to make this decision at this time. This standard might have allowed the psychiatrist to more readily conclude that though this patient literally understood his alternatives, he still lacked the capacity to appreciate them in a deeper and sufficient extent. A psychiatrist using the sliding standard might have reasoned that this patient was experiencing profound grief for his friends, as well as guilt and personal loss. The psychiatrist might have decided that when the patient was further from this experience and from these emotions, he might have wanted to live.

A sliding scale may require less cognitive ability. The sliding standard may allow psychiatrists to go more the "other way." This standard may allow a psychiatrist to respect a patient's autonomy to a greater extent by allowing the patient to decide what he or she wants, even when the patient lacks the capacity to literally understand the alternatives, which a more fixed standard might require.

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A case example. A woman (composite case, not a real patient) was mentally retarded since her birth. She acquired cancer and underwent several unsuccessful treatment trials, experiencing severe nausea and vomiting during each. Her internist asked her whether she wanted to undergo an additional treatment trial, but this patient had insufficient mental capacity to understand and describe her alternatives in the usual detail that was required. Now suppose this patient simply said "no," to any further treatment. A psychiatrist who assessed her capacity could have applied the sliding standard and more easily concluded through its use that this patient had sufficient capacity to make this decision. In this instance, there was relatively little difference between the two outcomes this patient confronted. She may have died sooner without a further trial of treatment on one hand, or on the other hand she may have lived longer with another trial of treatment, but for only a short time and with impaired quality of life due to nausea and vomiting.

In clinical contexts such as this, in which there is a relatively small difference between potential outcomes, the use of the sliding standard may allow the psychiatrist to further take into account what the patient wants.[27] Ethically, a greater emphasis on respecting a patient's autonomy makes sense when medicine has less to offer him or her.

Finally, a sliding standard that requires less capacity than is required under a fixed standard may, in some circumstances, also benefit patients in addition to respecting their autonomy.[28] For example, a sliding standard may allow a patient to accept urgently needed life-saving treatments, such as surgery, immediately without having to take the time for additional assessments and/or the appointment of a surrogate decision maker. This time could even be the difference in whether this patient lives or dies.[29]

Assessing the capacity of patients only when they refuse treatment. Physicians often ask psychiatrists to determine patient capacity only when a patient refuses treatment. They do not, however, ask psychiatrists for a consult when a patient accepts treatment, though objectively the ground for concern regarding patient capacity in both cases may be the same. Physicians who do this, some critics claim, may do it to fulfill and impose their own values; doctors may do it, they assert, to fulfill their own desire to most benefit and/or even save their patients' lives. This claim is empirically correct, in that many doctors consult psychiatrists and ask them to determine patients' capacities more often when patients refuse needed treatments.

Doctors consulting with

psychiatrists "inconsistently" in this way, however, may be ethically justifiable if they are using a sliding standard. That is, if a patient will benefit significantly from accepting treatment in a way that he or she would not were the treatment refused, these two outcomes are highly discrepant. Thus, if a physician applied a sliding standard and requested a psychiatric consult to determine capacity only because a patient refused a life-saving therapy and may be mentally impaired, that may be ethically justifiable. It may even be morally obligatory.

Some physicians have adopted an ethically analogous sliding standard for use by surrogate decision makers when patients are incompetent. "Physicians have been largely silent in these discussions, yet…clinicians have developed their own methodology for balancing the prior preferences and the current interests of their incompetent patients."[30] Again, this may enable physicians to help these patients more when their potential outcomes are substantially different. The use of a sliding standard in this context allows surrogate decision makers to give more weight to these patients' best interests when there is a significant disparity between their potential alternatives. The more common practice presently is to give absolute priority to these patients' prior preferences, if and when they can be reasonably inferred. This present, predominant practice may be regarded as more analogous to psychiatrists determining capacity using a fixed standard. This present practice of determining incompetent patients' treatment on the basis of their prior preference alone gives priority to respecting patients' autonomy, even when it is not most beneficial to them.

Ethical judgments when choosing or applying these standards or when using the sliding standard. When psychiatrists choose which standard to use, this cannot help but reflect their personal ethical beliefs to some extent, as I have said previously. Further, if they do use the sliding standard, this decision may reflect their own moral views in a different way. That is, psychiatrists who use the sliding standard may place different weights on different factors when they determine patient capacity. Reconsider, as an example of this, the patient who was speeding. One psychiatrist examining this patient's capacity might place the greatest weight on the patient's present affect when determining capacity; another psychiatrist might place greatest weight on what has just happened to the patient, regardless of whether or not the patient reflects the tragedy in his affect.

Since decisions may involve a psychiatrist's personal and even idiosyncratic values, and these values may differ from one psychiatrist to another, this may be ethically problematic. Accordingly, there are ways in which a psychiatrist might reduce the negative risks of imposing his or her own belief system onto the determination of a patient's mental capacity.

PRACTICAL IMPLICATIONS

Recognizing one's bias. Since a psychiatrist's personal value bias may make a critical difference in what he or she concludes regarding a patient's capacity and since this would be ethically suboptimal, a psychiatrist should always try to identify when he or she has a strong moral view in each case. One way to do this is for the psychiatrist to ask him- or herself prior to assessing a patient for mental capacity whether he or she hopes the determination will work out one way over the other. If the psychiatrist is able to recognize that he or she has a strong feeling and/or a strong moral preference about how the determination should go and if his or her assessment agrees with this strong preference, the psychiatrist should ask him or herself if another psychiatrist would have made the same assessment. In answering this question, the psychiatrist should also consider whether there is anyone who has been involved with the patient who has already expressed or even implied a different view. This should include loved ones, of course, as well as the patient's care providers. If someone has expressed a different view, this suggests more strongly that the consulting psychiatrist should consider obtaining the second opinion of a colleague.

Being proactive and seeking a second "most different" opinion. When seeking a second opinion, the psychiatrist should ask a colleague whose value system is different from his or her own. Ideally, the psychiatrist would be familiar with the value systems of his or her colleagues well before the need to consult with them arises. The need for a second opinion may be urgent, which is why a psychiatrist should have this information in advance. This preliminary information on value systems could be obtained in advance by asking all those who would assess a patient's capacity how they would be inclined to respond to cases such as those I have presented here. Their responses to these cases should give a rough idea of their value leanings; this may be enough to know who first to ask.

There are, in fact, other contexts in which such a preliminary survey of physicians' personal views could

help patients. An example of this would be a patient who is a Jehovah's Witness who presents at the emergency room needing life-saving, emergency surgery. Surgery might pose a greater risk to the patient because, based on the patient's religion, no blood or blood products can be used. Yet some surgeons are willing to do surgery on the patient under the condition of not being able to use blood or blood products. Their legal liability if this patient becomes worse and even dies is not increased. If a surgeon is known to hold this view in advance, he or she can be identified and called to do this surgery sooner. This may, of course, result in saving the patient's life.

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Reporting the results of different conclusions. When a colleague has a different conclusion regarding a patient's capacity, the original consulting psychiatrist may then report this different view to whomever it is that must make the ultimate decision regarding the patient's capacity or competency. This additional information may, of course, make it more open to question whether the initial psychiatrist's assessment is the right one. This additional information adds to the validity of the final result though.[31] Providing this information to whomever it is that must make the ultimate decision regarding the patient's capacity or competency is especially important when the psychiatrist has strong feelings, a strong moral bias, or when another person has expressed a different view in regard to a patient's capacity. This is most important when the decision of whether or not a patient has capacity is marginal.

The psychiatrist may ask him- or herself when considering these options whether those duly authorized to make the ultimate decisions regarding capacity or competency, such as a judge or court, can or should be expected to make decisions any more valid than his or her own. Afterall, a judge or a court may also have personal feelings and biases. The answer here is that these ultimate decision makers' judgments may not be better, at least in any given case. There are other reasons, however, that these decision makers should be the ultimate decision makers of patients' competency. They usually must use predetermined procedures designed to maximize the degree to which they hear all conflicting views and consider all different moral values. The greater society has authorized these bodies to make this determination. This is likely to be ethically preferable to these decisions being made in some other, less-consistent way. This is likely to be preferable regardless of whether, in specific cases, these decisions are more right or wrong.

DIFFICULT NEW DETERMINATIONS

Several new questions have emerged recently that may challenge a psychiatrist's ability to remain optimally unbiased. These questions may or may not involve his or her having to determine a patient's mental capacity.

Patients whose decision-making capacities may be more impaired than we have known, based on new research. Recent findings have suggested that some patients with affective illness, particularly bipolar disorder, may have greater deficits in executive functioning than we have previously appreciated.[32–34] Further studies may suggest that there are similar deficits in other kinds of patients who engage in exceptionally high-risk behaviors, as well.[35]

Should psychiatrists change how they assess the capacities of these patients when they engage in high-risk behaviors? Or should their approaches, notwithstanding these findings, remain the same? An example illustrating the possible influence of new findings is the soldiers serving in Iraq and Afghanistan who are subjected to injury due to blasts. Some authorities believe that certain types of blasts may have different effects on the brain than other kinds of brain injuries, such as blunt trauma.[36,37] These patients may be especially prone, shortly after blasts and before their brains recover, to physically based emotional turmoil, even though they retain most or all of their *cognitive* capacity. Should psychiatrists seeing these patients to determine their capacity take these newly postulated possibilities into account?

Patients requesting new kinds of surgery. A wholly different kind of emerging challenge is when patients request new kinds of surgery. One example is women seeking a vaginoplasty for cosmetic reasons.[38,39] Psychiatrists have faced related ethical questions in the past.[40,41] How psychiatrists confront this new request may, however, be construed in quite different ethical

ways. Women wanting a vaginoplasty may want the operation because they hope to increase their own and/or their partners' experience of pleasure. If these patients want this procedure solely to please their male partners, however, psychiatrists supporting this may be seen on one hand as quite rightly supporting their autonomy, or on the other hand as colluding with and wrongly reinforcing society's sexism.

A still more troubling question posed by patients wanting "new" kinds of surgery are those who want surgeons to amputate healthy limbs.[42–44] These patients request amputation based on their strong subjective feeling that their limb is not part of them. Some authors have suggested that this feeling may be somewhat like the feeling of those who want surgery to change their bodies because they feel their bodies are the wrong gender. Some patients have had this amputation surgery outside the US. Counterintuitively, some of the relatively few who have had this surgery report that they have done well.[45] One patient states, for example, "since I had it done five years ago, I've felt the best I've ever felt."[45] A psychoanalyst who wants this surgery may help explain why this has occurred. He says, "It's about becoming whole, not becoming disabled…You have this foreign body, and you want to get rid of it."[46] It may also be that the feeling of a limb being a foreign body is neurologically based.[47] This operation has not been carried out on the basis of this possibility, but rather in response to these patients' strong feelings that this is what they wanted.

Patients having inner awareness that we previously have not imagined. A last question that may newly challenge psychiatrists is whether patients like those in a persistent vegetative state (PVS) might have inner awareness.[48–50] This question came into public discussion recently when doctors of a patient they believed to be in a PVS repeatedly asked her to imagine that she was playing tennis. They recorded her brain activity in response using functional magnetic resonance imaging (fMRI). She responded in a way that was consistent with this request.[51] If patients are diagnosed correctly as having PVS and they have any inner awareness, this most likely is extremely rare.

Still, physicians can never say with absolute certainty that any patient lacks inner awareness. With this finding and other studies consistent with this possibility, how should a psychiatrist respond when loved ones ask him or her about a patient's capacity? More specifically, how should a psychiatrist respond when loved ones ask whether they should keep the patient alive so that they can try to communicate with the patient in this same way?

CONCLUSION

A psychiatrist will face ethical and clinical challenges when determining a patient's mental capacities. This is in part because the psychiatrist will need to decide whether he or she will use a fixed or sliding standard. If the psychiatrist does use a sliding standard, he or she will then have to decide which clinical factors to give the greatest weight. A psychiatrist may have strong feelings and moral biases about particular issues, but these values should not be imposed on his or her patients.[52] Rather, his or her decisions should be ethically justifiable to the highest degree.

When a psychiatrist recognizes that he or she has strong feelings or a strong moral bias toward the determination of a patient's mental capacity or when a caregiver or family member of the patient disagrees in regard to the patient's capacity, the psychiatrist should consider obtaining a second professional opinion from someone whom he or she knows in advance has values most different from his or her own.

New questions likely to tax a psychiatrist's abilities to be optimally unbiased have and will continue to arise. A psychiatrist's awareness that his or her decisions *must* be *both* ethically and clinically based, however, may enable the psychiatrist to pursue some preferable therapeutic options.

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